

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 - 1957

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

41905

11280

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION <u>BETHESDA Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>6307 ALASKA</u>	
3. NAME OF DECEASED (Type or print) <u>HERMAN J. DIERKES</u>		4. DATE OF DEATH <u>Nov. 23 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 10 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICKLAYER</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS Mo</u>	
13. FATHER'S NAME <u>HENRY DIERKES</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE SICKING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>49307-8709</u>	
17. INFORMANT <u>MABEL DIERKES</u>		Address <u>4332 Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per item for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (b): arteriosclerosis + Hypertension stating the underlying cause last. DOE TO (c) <u>331X</u> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>arteriosclerosis nephrosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>23 days</u> <u>14 yrs</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1-12-42</u> to <u>11-23-57</u> and last saw her/him alive on <u>11-23-57</u> Death occurred at <u>7:00 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Max Starkloff MD</u>		22b. ADDRESS <u>512 Dover Place</u>	
22c. DATE SIGNED <u>11-25-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
23b. DATE <u>Nov. 25 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL</u>	
23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>		24. FUNERAL DIRECTOR <u>Thomas Kuter 2906</u>	
25. DATE RECD. BY LOCAL REG. <u>NOV 25 57</u>		26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 365

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.